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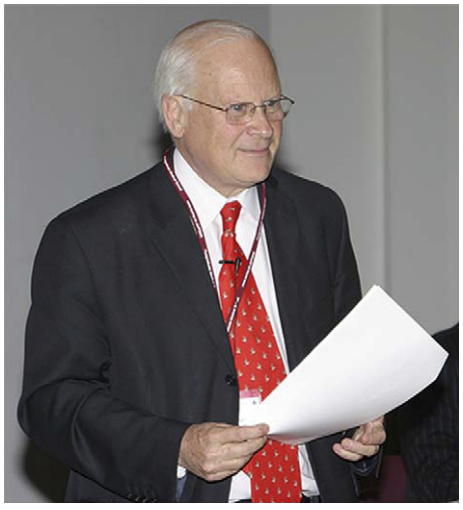
EDITORIAL

Valedictory editorial for the IJS



As I find myself halfway through my 70th year on this planet and as I will be shortly celebrating the 45th year as a registered doctor with my surviving classmates from Birmingham University School of Medicine, I thought it time to hang up my editorial hat and pass it on to someone younger and better in touch with our global surgical brotherhood/sisterhood. That last minute addition of sisterhood must tell you something. When I gained my Fellowship of the Royal College of Surgeons of England (FRCS) in 1965 there were no female fellows in my group whereas today I'm delighted to note that about half of our new FRCSs carry two X chromosomes. It is therefore appropriate for me to reflect on the changes I've witnessed in the practice of surgery in the last 40 years before I enter my ''anecdotage''.

Apart from all these bright young women bustling about the place there have been many obvious and equally glamorous developments in surgical techniques. Transplantation, minimally invasive surgery and interventional radiology immediately come to mind. In parallel with that have been the breathtaking advances in diagnostic imaging such as fibre-optic flexible endoscopy, CT and MRI scans. Of course along the way the invention of drugs such as the H2 receptor antagonists and antimicrobial therapy for peptic ulcers (two Nobel prizes here) has lead to the loss of much of the upper GI surgery that occupied nearly half of my general surgical lists in the late 1960s and early 1970s. Advances in trauma surgery, lead by doctors on the front line of civil unrest or outright war, have changed the face of A&E departments, and intensive care lead by our colleagues in the anaesthetic departments, continues to salvage victims of major injury or burns, who most certainly would have died in the first decade after I qualified.

Surgical research has flourished and academic departments of surgery burgeoned in number reaching a peak in the 1990s but now facing what looks like a terminal decline (*vide infra*). By surgical research I don't just mean research into surgical technique but a much broader definition, as research into disease that is commonly referred to surgeons. Surgeons have lead the way in randomised controlled trials even though the outcome of these trials has lead to a reduction in the number of surgical interventions in use, as exemplified above. Audit has emerged as an essential component of our everyday life and the ethics of our interactions with our patients has been researched and codified in a number of surgical textbooks.

But…something of immense value has been lost along the way. ''Oh dear'', I can hear you murmur behind your hands, ''Baum's going to talk about the Good Old Days!''. Well to an extent that's true. I think the trajectory of my experience as a surgeon has described a parabola with something like a golden age in the late 1970s until the early 1990s, that applies to not only the research ethic but to professionalism as a whole. I don't completely blame the constant re-disorganization of the National Health Service (NHS) or the European Union (EU) attempts at harmonization, I also blame some of our younger colleagues for allowing it to happen. Sure when I qualified, any time off was considered a rare privilege not a right and a lot of the time we were wickedly exploited propping up the NHS whilst our chiefs got on with the serious business of making money in the private sector. However, one thing of lasting value we learnt was the sense of total open-ended responsibility and continuity of care for the sick and the lame assigned to our watch. I will never forget the sense of guilt I

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felt when I was off duty and one of my charges developed complications or, God forbid, had to be re-operated on by another surgeon. This is what I mean by professionalism; an open-ended contract.

Thanks to cost cutting in the NHS and the malign interventions of the EU we have gone to another extreme. Hours are so tightly controlled that many junior doctors are not indemnified to even being on the premises of their hospital once they've completed their set time on duty. Furthermore, audit and clinical governance activities count towards their hours of duty, leaving less time for work and experience on the front line. Add to that shift work, annual leave, paternity/maternity leave, compassionate leave and study leave, no one seems to be left in charge, all that at a time when I enter the age bracket that may well need the skills and attention of a youthful surgeon.

You may think that these ideas are old fashioned and reactionary and that a proper work-life balance is equally important as professional responsibility. Well I confess I do subscribe to some pretty old-fashioned ideas that include politeness, chivalry, a work ethic and the constant need for reflection and research that goes on out of hours. Well the chickens have come home to roost. It is increasingly difficult to recruit academic surgeons, as time out for research interferes with the mechanics of the sausage machine that turns out surgical functionaries that will fulfil the EU requirements for specialist status. In addition academic departments of surgery are closing down or being subsumed into larger amorphous entities of life science research. One of the most bitter—sweet moments of this year was when I was asked to speak at the *festschrift* for one of my academic colleagues left over from my days as Professor of Surgery at Kings College School of Medicine and Dentistry. In those days we had three professors, three senior lecturers, umpteen lecturers and clinical research fellows but he was the last. His retirement ended the line of a distinguished academic unit that started with Lord Lister in 1908 and ended with a whimper as the last one to leave turned off the lights.

Ahh! I feel better for that rant which I found quite cathartic. I wish the journal a great future under new leadership but I will still keep a close eye on things in my role as Emeritus Editor-in-Chief.

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